

#	0036202	Report Period Beginning:	01/01/05	Ending:	12/31/05
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D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

**E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)**

None

F. Does the facility maintain a daily midnight census? Yes

YES ☐ NO ☒

YES ☐ NO ☒

Date started 06/18/90

YES ☒ Date 06/18/90 NO ☐

YES ☒ NO ☐ If YES, enter number

of beds certified 117 and days of care provided 16,091

Medicare Intermediary AdminaStar Federal

ACCRUAL	<input checked="" type="checkbox"/>	MODIFIED		
CASH*	<input type="checkbox"/>	CASH*	<input type="checkbox"/>	

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/05 **Fiscal Year:** 12/31/05

*** All facilities other than governmental must report on the accrual basis.**

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **83.08%**

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Manorcare Health Services Homewood # 0036202 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	209,789	14,621	962	225,372	3,211	228,583		228,583			1
2	Food Purchase		167,420		167,420		167,420	(211)	167,209			2
3	Housekeeping	119,591	18,635	398	138,624		138,624		138,624			3
4	Laundry	35,844	10,179	543	46,566		46,566		46,566			4
5	Heat and Other Utilities			149,837	149,837	6,498	156,335		156,335			5
6	Maintenance	37,918	7,933	84,709	130,560		130,560		130,560			6
7	Other (specify):* Medical Waste			1,330	1,330		1,330		1,330			7
8	TOTAL General Services	403,142	218,788	237,779	859,709	9,709	869,418	(211)	869,207			8
	B. Health Care and Programs											
9	Medical Director			19,500	19,500		19,500		19,500			9
10	Nursing and Medical Records	2,084,782	257,798	33,076	2,375,656	11,656	2,387,312		2,387,312			10
10a	Therapy	47,204	8,224	797,253	852,681		852,681		852,681			10a
11	Activities	55,539	3,080	1,736	60,355		60,355		60,355			11
12	Social Services	99,903			99,903		99,903		99,903			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,287,428	269,102	851,565	3,408,095	11,656	3,419,751		3,419,751			16
	C. General Administration											
17	Administrative	80,519		390,964	471,483	(88,131)	383,352		383,352			17
18	Directors Fees											18
19	Professional Services			30,802	30,802		30,802	(30,802)				19
20	Dues, Fees, Subscriptions & Promotions			48,100	48,100		48,100	(15,769)	32,331			20
21	Clerical & General Office Expenses	227,143	45,096	180,945	453,184		453,184	(149,137)	304,047			21
22	Employee Benefits & Payroll Taxes			543,259	543,259	48,427	591,686		591,686			22
23	Inservice Training & Education			1,329	1,329		1,329		1,329			23
24	Travel and Seminar			1,835	1,835		1,835		1,835			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			135,504	135,504		135,504		135,504			26
27	Other (specify):* Purch. Serv. Admin.											27
28	TOTAL General Administration	307,662	45,096	1,332,738	1,685,496	(39,704)	1,645,792	(195,708)	1,450,084			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,998,232	532,986	2,422,082	5,953,300	(18,339)	5,934,961	(195,919)	5,739,042			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			316,848	316,848	18,339	335,187		335,187			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,955	73,955		73,955		73,955			32
33	Real Estate Taxes			328,086	328,086		328,086		328,086			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			210,308	210,308		210,308		210,308			35
36	Other (specify):* Gain/Loss on Assets											36
37	TOTAL Ownership			929,197	929,197	18,339	947,536		947,536			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			7,162	7,162		7,162		7,162			38
39	Ancillary Service Centers		442,625	3,695	446,320		446,320		446,320			39
40	Barber and Beauty Shops			11,207	11,207		11,207		11,207			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):* IV X-Ray & Lab		66,700	46,972	113,672		113,672		113,672			43
44	TOTAL Special Cost Centers		509,325	134,736	644,061		644,061		644,061			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,998,232	1,042,311	3,486,015	7,526,558		7,526,558	(195,919)	7,330,639			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(211)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,328)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds		21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(829)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(30,802)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(143,766)	21		24
25	Fund Raising, Advertising and Promotional	(15,769)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,214)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (195,919)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (195,919)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (954)	21	1
2	Misc. Income	(260)	21	2
3	Loss on Disposal of Fixed Asset		36	3
4	Activity Income		11	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,214)		49

Summary A

Facility Name & ID Number	Manorcare Health Services Homewood	#	0036202	Report Period Beginning:	01/01/05	Ending:	12/31/05
SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I							

[illegible]

Summary B

Facility Name & ID Number	Manorcare Health Services Homewood	#	0036202	Report Period Beginning:	01/01/05	Ending:	12/31/05
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1OWNERS		2RELATED NURSING HOMES		3OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 390,964	HCR Manor Care, Inc.	100.00%	\$ 390,964	\$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	19,811	Heartland Management Services	100.00%	19,811		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 410,775			\$ 410,775	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Manorcare Health Services Homewood # 0036202 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization HCR Manor Care, Inc.
Street Address 333 North Summit St.
City / State / Zip Code Toledo, OH 43604-2617
Phone Number (419) 252-5500
Fax Number (419) 254-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,501,870,392	369 Nurs. Fac.	\$ 1,107,111	\$ 591,572	7,255,909	\$ 3,211	1
2	1	Dietary - Pooled	Accumulated Cost	3,038,404,432	369 Nurs. Fac.	0		7,255,909	0	2
3	5	Utilities - Direct	Accumulated Cost	2,501,870,392	369 Nurs. Fac.	267,575		7,255,909	776	3
4	5	Utilities - Pooled	Accumulated Cost	3,038,404,432	369 Nurs. Fac.	2,395,925		7,255,909	5,722	4
5	10	Nursing - Direct	Accumulated Cost	2,501,870,392	369 Nurs. Fac.	771,372	565,963	7,255,909	2,237	5
6	10	Nursing - Pooled	Accumulated Cost	3,038,404,432	369 Nurs. Fac.	3,944,092	2,235,491	7,255,909	9,419	6
7	17	General & Admin - Direct	Accumulated Cost	2,501,870,392	369 Nurs. Fac.	24,791,565	22,717,176	7,255,909	71,900	7
8	17	General & Admin - Pooled	Accumulated Cost	3,038,404,432	369 Nurs. Fac.	96,702,974	43,044,715	7,255,909	230,933	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,501,870,392	369 Nurs. Fac.	6,363,513		7,255,909	18,455	9
10	22	Employee Benefits - Pooled	Accumulated Cost	3,038,404,432	369 Nurs. Fac.	12,550,855		7,255,909	29,972	10
11	30	Depreciation - Direct	Accumulated Cost	2,501,870,392	369 Nurs. Fac.	0		7,255,909	0	11
12	30	Depreciation - Pooled	Accumulated Cost	3,038,404,432	369 Nurs. Fac.	7,679,242		7,255,909	18,339	12
13										13
14	32	Interest				25,847,975			0	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 182,422,199	\$ 69,154,917		\$ 390,964	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	National City Bank		X	Fin. Capital Additions 01/97		04/2004	\$ 1,104,955	\$ 1,104,955		6.2500	\$ 69,060	1	
2	National City Bank		X	Fin. Capital Additions 11/97		04/2004	78,359	78,359		6.2482	4,896	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8	Interest Income/Expense Other										(1)	8	
9	TOTAL Facility Related						\$ 1,183,314	\$ 1,183,314			\$ 73,955	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,183,314	\$ 1,183,314			\$ 73,955	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.		<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>		\$	334,864	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	326,823	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(8,041)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	336,628	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 604 For 1998 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	(501)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	328,086	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	288,954	8		
	2001	295,049	9		
	2002	306,195	10		
	2003	325,111	11		
	2004	326,823	12		

Line 2: \$326,823 is for 2004.

Line 4: \$336,628 = Property Tax paid for 2004 (\$326,823) plus 3% for estimated increase.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare Health Services Homewood COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0036202

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419) 252-5731 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
			Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 29-32-200-046-0000	See Attached	\$ 326,822.97	\$ 326,822.97
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 326,822.97	\$ 326,822.97

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: **39,083** B. General Construction Type: Exterior **Masonry** Frame **Wood** Number of Stories **3**

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1990	\$ 383,373	1
2					2
3	TOTALS			\$ 383,373	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1990		\$ 2,845,250	\$ 71,217		\$ 71,217	\$	\$ 1,103,281	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Current Year Depreciation					148,652		148,652		1,525,650	9
10	Land Improvement			1990	429,835						10
11	Building Improvement			1990	65,079						11
12	Land Improvement			1991	1,679						12
13	Building Improvement			1991	4,525						13
14	Land Improvement			1992	565						14
15	Building Improvement			1992	1,403						15
16	Land Improvement			1993	5,108						16
17	Building Improvement			1993	136,058						17
18	Land Improvement			1994	13,285						18
19	Building Improvement			1994	68,753						19
20	Land Improvement			1995	5,027						20
21	Building Improvement			1995	421,042						21
22	Land Improvement			1996	20,361						22
23	Building Improvement			1996	506,756						23
24	Land Improvement			1997	8,235						24
25	Building Improvement			1997	70,208						25
26	Land Improvement			1998	20,770						26
27	Building Improvement			1998	80,701						27
28	Building Improvement			1999	31,240						28
29	Bldg. Improvement: Wallcovering, Paper, Paint, & Corner Guards			2000	34,575						29
30	Bldg. Improvement: Carpet			2000	8,718						30
31	Bldg. Improvement: Signs			2000	639						31
32	Land Improvement: Sign			2000	1,385						32
33	Land Improvement			2001	none						33
34	Building Improvement			2001	none						34
35	Land Improvement			2002	none						35
36	Building Improvement			2002	none						36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Renovation construction Dept. costs & Interest on financing	2003	\$ 5,781	\$		\$	\$		37
38	Carpet, Paint, & Wallcovering	2003	147,107						38
39	Wallcovering & Borders	2003	1,895						39
40	Carpet	2003	101						40
41	Paint, Wallcovering, & Borders	2003	8,010						41
42	Electric wiring	2003	2,870						42
43	Parking lot sealing & striping	2003	35,895						43
44	Sidewalk	2003	3,873						44
45	Paint, Wallcovering, & Borders	2004	1,015						45
46	Doors	2004	3,557						46
47	Flooring & Base	2004	24,082						47
48	Carpet	2004	20,461						48
49	Carpet	2005	1,080						49
50	Flooring	2005	58,964						50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,095,888	\$ 219,869		\$ 219,869	\$	\$ 2,628,931	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,700,253	\$ 96,979	\$ 96,979	\$		\$ 1,497,455	71
72	Current Year Purchases	41,402						72
73	Fully Depreciated Assets							73
74	Home Office Depr			18,339	18,339			74
75	TOTALS	\$ 1,741,655	\$ 96,979	\$ 115,318	\$ 18,339		\$ 1,497,455	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,220,916	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 316,848	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 335,187	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 18,339	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,126,386	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 209,505
- Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Transportation	1992 Ford Supreme Bus	\$ 35.00	\$ 803	17
18				Above figure includes	18
19				gas & maintenance too.	19
20					20
21	TOTAL		\$ 35.00	\$ 803	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☒ NO

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
COMMUNITY COLLEGE
HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
HOURS PER CNA

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	10a	311 hrs	\$ 8,645	7,154	\$ 292,402	\$ 3,519	7,465	\$ 304,566	1
2	Licensed Speech and Language Development Therapist	10a	139 hrs	3,501	1,787	73,017	309	1,926	76,827	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	590 hrs	17,368	10,034	410,089	4,396	10,624	431,853	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				442,625		442,625	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): X-ray & Lab	43, 3				46,972			46,972	13
14	TOTAL			\$ 29,514	18,975	\$ 822,480	\$ 450,849	20,015	\$ 1,302,843	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (623)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 221,440)	1,333,968		3
4	Supply Inventory (priced at 12/31/05)	33,154		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	237		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,366,736	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	383,373		13
14	Buildings, at Historical Cost	5,095,888		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,741,655		16
17	Accumulated Depreciation (book methods)	(4,126,386)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction In Progress			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,094,530	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,461,266	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 117,110	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	198,090		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	336,628		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	112,643		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 764,471	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,183,314		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,183,314	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,947,785	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,513,481	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,461,266	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,909,381	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,909,381	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,006,675	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,006,675	17
	B. Transfers (Itemize):		
18	Changes in Interdivison	(2,402,575)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2,402,575)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,513,481	24

*

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,901,890	1
2	Discounts and Allowances for all Levels	(468,339)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,433,551	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,608,532	6
7	Oxygen	3,535	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,612,067	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	954	12
13	Barber and Beauty Care	10,862	13
14	Non-Patient Meals	211	14
15	Telephone, Television and Radio	3,328	15
16	Rental of Facility Space		16
17	Sale of Drugs	447,317	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,632	19
20	Radiology and X-Ray	300	20
21	Other Medical Services		21
22	Laundry	260	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 487,864	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income		28
28a	Late Charges	(249)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (249)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,533,233	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	859,709	31
32	Health Care	3,408,095	32
33	General Administration	1,685,496	33
	B. Capital Expense		
34	Ownership	929,197	34
	C. Ancillary Expense		
35	Special Cost Centers	578,361	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,526,558	40
41	Income before Income Taxes (line 30 minus line 40)**	2,006,675	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,006,675	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,151	2,331	\$ 87,925	\$ 37.72	1
2	Assistant Director of Nursing	3,768	4,082	116,742	28.60	2
3	Registered Nurses	17,726	19,205	512,205	26.67	3
4	Licensed Practical Nurses	26,288	28,481	588,948	20.68	4
5	CNAs & Orderlies	74,372	80,577	757,076	9.40	5
6	CNA Trainees					6
7	Licensed Therapist	1,040	1,123	31,866	28.38	7
8	Rehab/Therapy Aides	728	786	15,338	19.51	8
9	Activity Director	4,882	5,289	55,539	10.50	9
10	Activity Assistants					10
11	Social Service Workers	4,880	5,292	99,903	18.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,932	19,447	209,789	10.79	15
16	Dishwashers					16
17	Maintenance Workers	1,995	2,163	37,918	17.53	17
18	Housekeepers	12,575	13,637	119,591	8.77	18
19	Laundry	3,970	4,302	35,844	8.33	19
20	Administrator	2,080	2,080	80,519	38.71	20
21	Assistant Administrator					21
22	Other Administrative	13,501	15,063	227,143	15.08	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,528	1,653	21,886	13.24	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	189,416	205,511	\$ 2,998,232 *	\$ 14.59	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	19,500	9, 3	36
37	Medical Records Consultant		1,430	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,920	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 28,850		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

****See instructions.**

(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$7042

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes \$1299

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 55,699 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,700
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 211

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____

c. What percent of all travel expense relates to transportation of nurses and patients? N/A

d. Have vehicle usage logs been maintained? N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.